

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

490 63-029108

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 381

Primary Registration District No. 3087

Registrar's No. 480

STATE FILE NUMBER

FILED JUL 17 1963

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF	DOCUMENT
1 0585			
2 0585			
3			
4 0			
5 1			
6			
7 1			
8 0			
9 332X			
10			
11			
12 86-0			
13 20			
ITEM NO.	SHOULD READ	BY AFFIDAVIT OF	

1. PLACE OF DEATH a. COUNTY <u>Lincoln</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lincoln</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Brookfield</u>		c. CITY OR TOWN <u>Brookfield</u>	
Length of stay in 1b <u>4 months</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Boise Rest Home</u>		d. STREET ADDRESS (If outside, give location) <u>210 South Pennsylvania</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>ALLEN</u> Last <u>ALLEN</u>		4. DATE OF DEATH <u>July 9, 1963</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/7/1879</u>
9. AGE (last birthday) <u>83</u>		10. BIRTHPLACE (City and state or country) <u>Weldon, Illinois</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>William Allen</u>		13b. MOTHER'S MAIDEN NAME <u>Ann Elizabeth Johnson</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		15. SOCIAL SECURITY NO. <u>1-10-63</u>	
16. NAME OF HUSBAND OR WIFE <u>Laura Bell Allen</u>		17. ADDRESS <u>Brookfield, Missouri</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____	
21. I attended the deceased from <u>6-23-63</u> to <u>7-9-63</u> and last saw her alive on <u>7-9-63</u> Death occurred at <u>12:20</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John R. Dyer M.D.</u> (Degree or title)		22b. ADDRESS <u>Brookfield Mo</u>	
22c. DATE SIGNED <u>7-10-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 11, 1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town, or county) <u>Brookfield, Missouri</u>	
24. FUNERAL DIRECTOR <u>Hill Funeral Home, Brookfield, Mo.</u> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>7-10-63</u>	
26. REGISTRAR'S SIGNATURE <u>Carroll Watson</u>			

(Licensed Embalmer's Statement on Reverse Side)

JUL 18 1969

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.